

Managed Care Resource Guide



Commonwealth of Virginia

Managed Care HelpLine

800-643-2273

TDD 800-817-6608

www.dmasva.dmas.virginia.gov

ManagedCareHelp@dmas.virginia.gov

www.virginiamanagedcare.com

<http://www.famis.org/>

Department of Medical
Assistance Services

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IMPORTANT: This is a reference guide only.
Information contained in this guide is subject to change without notice

MANAGED CARE RESOURCE GUIDE

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1. Overview of the Virginia Medicaid and FAMIS Program Delivery Systems

The Department of Medical Assistance Services (DMAS)

administers the Medicaid and FAMIS Plus programs, in accordance with Title XIX of the Social Security Act (FAMIS Plus is Virginia Medicaid's designation for its covered children). DMAS also administers the Virginia Children's Health Insurance Program (CHIP), known as FAMIS (Family Access to Medical Insurance Security) under Title XXI of the Social Security Act. Medicaid and FAMIS programs are financed by Federal and State funds, administered by the State according to Federal and State guidelines, and are monitored closely by DMAS staff and the Centers for Medicare and Medicaid Services (CMS).

Medicaid Fee-For-Service and Managed Care Delivery Systems

DMAS provides Medicaid/FAMIS Plus coverage to members primarily through two delivery systems: fee-for-service (FFS) and managed care. FFS benefits are administered by DMAS through participating providers within the traditional Medicaid program rules; in accordance with Federal and State regulations; and as described in the applicable DMAS provider manuals. Provider Manuals are available on the DMAS website at:

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>.

DMAS operates one Medicaid mandatory managed care program, Medallion II, in accordance with a CMS 1915(b) Managed Care Waiver, and in accordance with Federal and State Regulations. The Medallion II program is administered through six of DMAS' contracted managed care organizations (MCO).



FAMIS Programs and Delivery Systems

DMAS operates 3 FAMIS benefits programs: 1) the FAMIS program for children under age 19; 2) FAMIS Select (a premium payment allowance for members eligible for employer offered benefits); and, 3) FAMIS MOMS, coverage for FAMIS eligible pregnant women. Except for FAMIS Select, FAMIS benefits are administered through DMAS contracted MCOs or through FAMIS fee-for-service. Additional information on all three FAMIS programs is provided in Section 4 of this guide.

Fee-for-Service (FFS)	
Program Name	Description
Medicaid Fee-for-Service	Standard Medicaid Program under Title XIX.
FAMIS (Family Access to Medical Insurance Security Plan)	A Title XXI Children's Health Insurance Plan (CHIP).
Managed Care Organizations (MCOs)	
Program Name	Description
Medallion II	A Title XIX Medicaid program, requiring mandatory participation for qualifying members, that utilizes contracted managed care organizations (MCOs).
FAMIS MCO (Family Access to Medical Insurance Security Plan)	Title XXI Children's Health Insurance Plan (CHIP).

2. Medallion II (Medicaid/FAMIS Plus MCO Program)

The Medallion II program is a fully capitated, risk-based, mandatory managed care program for Medicaid and FAMIS Plus members. Under Medallion II, DMAS contracts with managed care organizations (MCOs) for the provision of most Medicaid covered services. The contracted MCO receives a capitated payment each month that covers a comprehensive set of services, regardless of how much care is used by the member. Claims for Medallion II services are paid by the MCO in accordance with Federal and State guidelines as well as the MCO/provider negotiated contracts. In most areas of the Commonwealth, qualified Medicaid/FAMIS Plus members choose between at least two contracted MCOs (*see Medallion II/FAMIS MCO Participation by Locality*). There are currently 6 DMAS contracted MCOs: Amerigroup Community Care, Anthem HealthKeepers Plus, CareNet by Southern Health, MajestaCare-A Health Plan of Carilion Clinic, Optima Family Care, and Virginia Premier Health Plan. As of July 1, 2012, MCOs operate in 134 Virginia localities with enrollment over 650,000.

Member Participation in Medallion II

Not all Medicaid/FAMIS Plus* members residing in Virginia are eligible for enrollment in a MCO. Medallion II eligibles include non-institutionalized members in the following covered groups:

- ◆ Families and children-related groups; and,
- ◆ Persons aged, blind, or disabled

In order to see Medallion II members, providers must become part of the MCOs' networks and follow their rules and regulations.

Members will receive most services through their MCO, and must follow the rules of that MCO for referrals, appointments, and other administrative requirements. By contract, members do not have to get referrals from their PCP for the following services:

- ◆ Immunizations
- ◆ Family Planning/OB/GYN services
- ◆ Mental health/mental retardation state plan option services/substance abuse services
- ◆ School health services

Eligible members can enroll in an MCO or obtain additional information by calling the Managed Care HelpLine at:

1-800-643-2273 (TTY/TDD 1-800-817-6608)
8:30 am-6 pm, Monday through Friday

Detailed information is also provided at
www.virginiamanagedcare.com.

*FAMIS Plus is the name for children's Medicaid. These members receive the same services as Medicaid members.

Some members in these groups are not Medallion II eligible because they meet exclusionary criteria, as described on the next page of this guide.

The services listed below are "carved out" of the MCO contract and are covered and reimbursed by DMAS in accordance with DMAS program rules. Reference the chart in Section 13 of this guide for information on how to access carved out services.

- ◆ Community mental health rehabilitation services, mental retardation services, and substance abuse treatment services as set forth in 12 VAC 30-50-226 (Mental Health), 12 VAC 30-50-440 (Mental Retardation), and 12 VAC 30-50-228 (Substance Abuse).
- ◆ School Health Services (local education agencies/public schools).
- ◆ Targeted Case Management (except for high-risk maternity-infant targeted case management, i.e., Baby Care) and Treatment Foster Care-CM
- ◆ Investigations by local health departments to determine the source of lead contamination for children diagnosed with elevated blood lead levels, as set forth in 12 VAC 30-50-227
- ◆ Abortions as set forth in 12 VAC 30-50-180 and 42 CFR 441.203 and 441.206
- ◆ Specialized infant formula available through VDH WIC clinics and medical foods for enrollees under age 21 (*enteral equipment and supplies are covered through the child's MCO*)
- ◆ Early and Periodic Screening Diagnosis and Treatment (EPSDT) Personal Care Services
- ◆ Early Intervention Services

Exclusion from Medallion II

In accordance with 12VAC30-120-370, the following members shall be excluded from participating in Medallion II. Members not meeting the exclusion criteria must participate in the Medallion II program.

1. Members who are inpatients in state mental hospitals.
2. Members who are approved by DMAS as inpatients in long-stay hospitals* (Article IID1.b. in the Medallion II Managed Care Contract), nursing facilities, or intermediate care facilities for the mentally retarded (MCO members who become enrolled in the Technology Assisted Waiver continue to be disenrolled from the MCO).
3. Members who are placed on spend-down.
4. Members who are participating in Plan First.
5. Members who are participating in the tech waiver or in federal waiver programs for home-based and community-based Medicaid coverage prior to managed care enrollment.
6. Members who are participating in foster care** (except the city of Richmond) or subsidized adoption programs.
7. Members under age 21 who are approved for DMAS residential facility Level C programs as defined in [12VAC30-130-860](#).
8. Newly eligible members who are in the third trimester of pregnancy and who request exclusion within a department-specified timeframe of the effective date of their MCO enrollment. Exclusion may be granted only if the member's obstetrical provider (e.g., physician, hospital, and midwife) does not participate with the enrollee's assigned MCO. Exclusion requests made during the third trimester may be made by the member, MCO, or provider. DMAS shall determine if the request meets the criteria for exclusion. Following the end of the pregnancy, these members shall be required to enroll to the extent they remain eligible for Medicaid.
9. Members, other than students, who permanently live outside their area of residence for greater than 60 consecutive days except those members placed there for medically necessary services funded by the MCO.
10. Members who receive hospice services in accordance with DMAS criteria.
11. Members with other comprehensive group or member health insurance coverage, including Medicare, insurance provided to military dependents, and any other insurance purchased through the Health Insurance Premium Payment Program (HIPP).
12. Members requesting exclusion who are inpatients in hospitals, other than #1 and #2 above of this subsection, at the scheduled time of MCO enrollment or who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the MCO enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge. This exclusion reason shall not apply to members admitted to the hospital while already enrolled in a department-contracted MCO.
13. Members who request exclusion during preassignment to an MCO or within a time set by DMAS from the effective date of their MCO enrollment who have been diagnosed with a terminal condition and who have a life expectancy of six months or less. The member's physician must certify the life expectancy.
14. Certain members between birth and age three certified by the Department of Behavioral Health and Developmental Services as eligible for services pursuant to Part C of the Members with Disabilities Education Act (20 USC § 1471 et seq.) who are granted an exception by DMAS to the mandatory Medallion II enrollment.
15. Members who have an eligibility period that is less than three months.
16. Members who are enrolled in the Commonwealth's Title XXI CHIP program.
17. Members who have an eligibility period that is only retroactive.
18. Children enrolled in the Virginia Birth-Related Neurological Injury Compensation Program established pursuant to Chapter 50 (§ [38.2-5000](#) et seq.) of Title 38.2 of the Code of Virginia.
19. Members residing in a locality where a single health plan is operating; where the member has an established medical home; and, where their medical home provider refuses or is otherwise ineligible to participate with the Contracted MCO per requirements described in Article II.G.43 (Medallion II Managed Care Contract) for out-of-network coverage.

*The member's HCB services (including transportation to HCB services) are managed and paid for under the DMAS fee-for-service program

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** Foster care children
under the custody of the
City of Richmond
Department of Social
Services and who are not
in residential treatment
centers; Non-custodial
children who are not in
residential treatment
centers; and, Minor
children of eligible foster
care children, i.e.
newborns are **ELIGIBLE** for
enrollment in the
managed care program
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Members enrolled with a MCO who subsequently meet one or more of the aforementioned criteria during MCO enrollment shall be excluded from MCO participation as determined by DMAS, with the exception of those who subsequently become members in the federal long-term care waiver programs, as otherwise defined elsewhere in the contract for home-based and community-based Medicaid coverage (AIDS, IFDDS, MR, EDCD, Day Support, or Alzheimer's, or as may be amended from time to time). These members shall receive acute and primary medical services via the MCO and shall receive waiver services and related transportation to waiver services via the fee-for-service program.

Members excluded from mandatory managed care enrollment shall receive Medicaid services under the current fee-for-service system. When enrollees no longer meet the criteria for exclusion, they shall be required to enroll in the appropriate managed care program.

3. Family Access to Medical Security Insurance (FAMIS) Program



FAMIS

FAMIS benefits are administered through DMAS contracted MCOs or through FAMIS fee-for-service (through DMAS). Like Medallion II, the FAMIS MCO program also operates under a risk-based capitated payment contract. DMAS contracted MCOs for FAMIS are the same as those contracted with DMAS for Medallion II.

In most areas of the state, FAMIS enrollees have the choice between 2 or more MCOs. In areas where only one MCO participates, the enrollee may request reassignment to fee-for-services (FFS).

FAMIS benefits are slightly different from the benefits under Medicaid (i.e., through Medallion II and Medicaid FFS). (Reference the covered services grid in Section 13 of this guide for a detailed listing of covered services). There are benefit limitations and small co-payments much like those associated with commercial group health insurance.

The following services (while covered under Medicaid) are **NOT** covered under FAMIS:

- EPSDT services – Early and Period Screening Diagnosis and Treatment services are not a covered service for FAMIS MCO members; however, is covered for FAMIS FFS members because they receive the Medicaid benefit package. Many of the services that are covered as EPSDT services by Medicaid are covered under FAMIS MCO's well child and immunization benefits.
- Psychiatric Treatment in free standing facilities is not covered (but is covered when provided in a psychiatric unit of an acute hospital)
- Routine transportation to and from medical appointments is not covered. (Exception: Children enrolled in FAMIS FFS may receive non-emergency transportation services.) Emergency transportation is covered for both FAMIS FFS and FAMIS MCO members.
- Temporary Detention Orders (TDOs) are not covered. Coverage may be available thru the TDO program.

FAMIS MOMS

FAMIS MOMS provides enrollees the same coverage that pregnant women currently receive from the Virginia Medicaid program. FAMIS MOMS expands this coverage to include pregnant women with family income less than or equal to 200% of the Federal Poverty Level (FPL). There is no difference in covered services, service limitations, and pre-authorization requirements. FAMIS MOMS use the same health care services delivery system (fee for service or managed care organizations) as FAMIS. There are no co-pays for pregnancy related services nor family planning services/supplies/drugs.

Children Born to FAMIS or FAMIS MOMS Enrolled Mother

Children born to teen mothers enrolled in FAMIS are deemed to be eligible for coverage under FAMIS Plus for their first year and are automatically enrolled in coverage upon report of the birth. Also, children born to mothers enrolled in FAMIS MOMS are deemed to be eligible for coverage under FAMIS for their first year and are automatically enrolled in coverage upon report of the birth. The DMAS-213 form has been revised to include reporting information for children born to FAMIS and FAMIS MOMS enrolled mothers. This allows hospitals and MCOs serving the FAMIS and FAMIS MOMS population the ability to notify the FAMIS Central Processing Unit (CPU) of the child's birth using the DMAS-213 form. Staff at the FAMIS CPU will determine whether the child is eligible for FAMIS Plus or FAMIS and will enroll the child in the appropriate coverage.

FAMIS Select

FAMIS *Select* is a program that gives parents of FAMIS enrolled children the freedom to choose between covering their children with the FAMIS health insurance plan or with a private or employer's health plan. FAMIS *Select* gives parents the choice to purchase private or employer sponsored health insurance with up to \$100 per child per month to help pay the child's part of the premium. In some cases, a private or employer plan may give a family more choice of providers. For some families, the FAMIS *Select* payment will be enough to make health coverage affordable for the entire family.

FAMIS Central Processing Unit (CPU)

Families may call the FAMIS Central Processing Unit (1-866-873-2647), their local DSS, or a Local Outreach Assistance Project for questions pertaining to FAMIS eligibility. To check on the status of a FAMIS application, families should contact the place at which they applied for FAMIS benefits.

FAMIS Cost Sharing

Under FAMIS there are no enrollment fees or monthly premiums. Most services rendered to FAMIS children in MCOs except well-child, preventive care, and immunization services, requires co-payments from the enrollee. FAMIS co-payments are typically \$2 or \$5 depending on income for most services. The table below provides more detail on copayments by type of service. Cost sharing cannot exceed \$180 per family per calendar year if a family's gross income is less than 150 percent of the federal poverty level and \$350 per family per calendar year if gross income is more than 150% of the federal poverty level. No cost sharing is charged to American Indian and Alaska Native children.

Copayment By Type of Service		
Type of Service	<150%	>150%
Chiropractic (Coverage is limited to 500 per calendar year)	\$2	\$5
Dental Services	\$0	\$0
Early Intervention (Coverage through DMAS Fee-For-Service)	\$0	\$0
ER Physician Charges (Emergent per Prudent Layperson)	\$2	\$5
Hospice	\$0	\$0
Home Health and Private Duty Nursing	\$2	\$5
Hospital ER (Emergent per Prudent Layperson)	\$2	\$5
Inpatient Services (Per Confinement) --Acute, Rehab, Psychiatric, Substance Abuse	\$15	\$25
Non-Emergency use of ER	\$10	\$25
Organ Transplants		
Facility	\$15	\$25
Out Patient	\$2	\$5
<i>Donor identification Services - limited to \$25,000 per member)</i>		
Outpatient Services (Medical, Mental Health, and Substance Abuse Treatment Services)	\$2	\$5
Physician (Primary, Specialty, Maternity)	\$2	\$5
<i>Pap Smears require no co-pay</i>	No copayments for maternity	No copayments for maternity
<i>Physician Inpatient requires no co-pay</i>		
Pregnancy or Family Planning Services/Supplies/Drugs	\$0	\$0
Prescription Drugs		
Retail, up to 34 day supply	\$2	\$5
Retail 35 – 90 day supply	\$4	\$10
Mail service up to 90 day supply	\$4	\$10
<i>(If a generic is available, enrollee pays co-payment plus 100% of the difference between the allowable of the generic drug and the brand drug.)</i>		
Second Opinions	\$2	\$5
Skilled Nursing Facility	\$15	\$25
Therapy (PT, OT, Speech)	\$2	\$5
Vision Services-- Routine eye exam (one per 24 months)	\$2	\$5
Well Child Care, Immunizations, Lead Testing	\$0	\$0
Other Services (Emergency Transportation, Hearing Aids, Lab and X-ray, Durable Medical Equipment*, Prosthetics/ Orthotics). <i>*Supplies require no copayment</i>	\$2	\$5
Annual Co-Payment Limit	<150%	>150%
Calendar Year Limit / Per Family	\$180 per family	\$350 per family
<i>Plan pays 100% of allowable charge once limit is met for covered services.</i>		

For the most up-to-date information on FAMIS, visit the FAMIS website at: <http://www.famis.org/>.

4. Verifying Eligibility and Enrollment (MCO or FFS)

All providers of services must verify program eligibility at each visit. Medicaid/FAMIS Plus and FAMIS eligibility can change. Relying on the permanent plastic card or even a newly issued MCO card does not guarantee current eligibility or reimbursement. Providers should know the payer source before services are rendered.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, check status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the ACS Web Portal Support Helpdesk; toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access service authorization information including status via KePRO's Provider Portal at <http://dmas.kepro.org/>.

ELIGIBILITY VENDORS

DMAS has contracts with the following eligibility verification vendors offering internet real-time, batch and/or integrated platforms. Eligibility details such as eligibility status, third party liability, and service limits for many service types and procedures are available. Contact information for each of the vendors is listed below.

Passport Health Communications, Inc. www.passporthealth.com sales@passporthealth.com Telephone: 1 (888) 661-5657	SIEMENS Medical Solutions – Health Services Foundation Enterprise Systems/HDX www.hdx.com Telephone: 1 (610) 219-2322	Emdeon www.emdeon.com Telephone: 1 (877) 363-3666
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“HELPLINE”

The “HELPLINE” is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The “HELPLINE” numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the “HELPLINE” is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

MediCall

Providers call MediCall at **800-884-9730 or 800-772-9996** to verify eligibility. The MediCall line will give member eligibility, special indicator codes, Managed Care Program assignment (including coverage dates), or MCO provider name.

MediCall is operational 24 hours a day 365 days a year. Although MediCall is designed to be accessed by touch-tone phone, dial phone may be used. A live operator is available 8:30 a.m. to 4:30 p.m.

Information required to use MediCall includes your National Provider Identifier (NPI) number or your A-typical Provider Identification (API) number, the Member Medicaid ID number OR the Social Security Number and date of birth, and the From and Through date(s) of service--a single date or dates spanning not more than 31 days. Providers also may check reimbursement, check status inquiry, and claims status inquiry from the most recent three remittances.

5. Medicaid Managed Care Helpline

The Medicaid Managed Care Helpline (MC Helpline) is a toll-free telephone helpline #1-800-643-2273 and TDD# 1-800-817-6608 customer service call center, available to Medallion II *eligible or enrolled* members. The MC Helpline provides detailed information about enrollment choices primarily to assist members in making an informed decision about the most appropriate MCO to meet their health care needs. The MC Helpline operates from 8:30 AM to 6:00 PM, Monday through Friday except on State holidays.

The functions of the Managed Care Helpline include, but are not limited to:

- Enrolling members into an MCO, initially or as a change.
- Educating members about managed care health plans in their locality.
- Assisting members with questions, referring members to appropriate resources for resolution of health care issues and billing related issues, tracking member complaints, and providing complaint information to DMAS.
- Triaging of telephone calls to participating health plans, member services departments, local Department of Social Services (DSS) agencies or the Department's member and provider HelpLines.
- Completing Health Status Assessments (HSA) on MCO members and forwarding information to the participating MCO that the member has selected.

Functions excluded from the Managed Care Helpline include, but are not limited to:

- Entering or modifying member eligibility information such as name, address, telephone number, date of birth, FIPS code, Aid Category, TPL, etc. **This is a function of the local DSS.**
- Verification of eligibility requests: DMAS has mechanisms for providers to verify member eligibility including the Audio Voice Response System (AVRS), formerly called the REVS line, and the DMAS web based system. The MCOs also provide assistance to verify their member eligibility.
- Issuance of any ID cards.

Information on Managed Care, including details on how to enroll, open enrollment, MCOs available by locality, etc., is also available on the Managed Care Helpline website at www.virginiamanagedcare.com.

FAMIS Managed Care

There are six MCOs administering FAMIS in Virginia. Different MCOs serve different parts of Virginia. Members may call FAMIS at 1-866-87FAMIS (1-866-873-2647) to find out which MCOs are offered in their area, for general questions, or to request change to another plan. Please note there are no open enrollment periods for FAMIS. If the member is within the first 90 days of enrollment with a particular MCO and wishes to change to another MCO in the area, they may contact FAMIS (1-866- 873-2647) to request the change. After 90 days, the member will remain with that MCO until their annual renewal. When the member's FAMIS coverage is renewed each year, they will have a chance to choose another MCO (if available in their locality) or remain with the current health plan. If they do not want to make a change, the member will remain with the current MCO. Members, who have questions or concerns about receiving services, may contact member services with the MCO (see Section 12 for contact information).

HEALTH STATUS SURVEY QUESTIONNAIRE

I would like to ask you some questions about your health and the health of any other MCO members in your house. The information you give me will go to the MCO. It's helpful for the MCO to know something about their new members so they can begin planning for your care. Do you have a minute to answer these questions?

Some of these questions are personal, and your answers will be confidential and private—only the MCO will get this information.

Please answer for yourself and everyone in your house who is a member of the MCO.

Case Head:		Case Head SSN:		Case Head Language:	
Last Name		First Name		Medicaid ID#	
Address		City		State/Zip	Ph#
1.	Gender			<input type="checkbox"/> Male <input type="checkbox"/> Female	
2.	Date of Birth				
3.	What MCO are you choosing?		Name:		
4.	Do you have a doctor you want to be your Primary Care Provider?		Name:		
5.	If you have a regular doctor now, what is the doctor's name?			Names:	
6.	Are you seeing any specialists (doctors who specialize in a particular field of medicine, such as a cardiologist)? [If yes] What are the names?			<input type="checkbox"/> Yes <input type="checkbox"/> No List:	
7.	Are you taking medicines that a doctor has prescribed? [If yes, ask what they are and what they're for.]			<input type="checkbox"/> Yes <input type="checkbox"/> No List:	
8.	Are you using any durable medical equipment; such as, a hospital bed, oxygen, a wheelchair, a breathing machine—anything like that? If yes, did a doctor prescribe it?			<input type="checkbox"/> Yes <input type="checkbox"/> No What: <input type="checkbox"/> Yes <input type="checkbox"/> No	
9.	Are you pregnant? [If yes], <ul style="list-style-type: none"> ▪ When is the baby due? ▪ Does the doctor have any special concerns about this pregnancy? 			<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
Now I'm going to read a list of health problems, and you tell me if you or anyone in the family has that problem.					
10.	Do you have surgery planned for the future? If yes, what is the date of surgery?			<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
11.	Are you getting home care or home hospice care? If yes, please explain.			<input type="checkbox"/> Yes <input type="checkbox"/> No Explanation:	
12.	Are you on an organ transplant list? If yes, please explain.			<input type="checkbox"/> Yes <input type="checkbox"/> No Explanation:	
13.	Are you getting physical therapy, or occupational therapy, or speech therapy?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
14.	Do you have a heart condition— such as congestive heart failure?			<input type="checkbox"/> Yes <input type="checkbox"/> No	

HEALTH STATUS SURVEY QUESTIONNAIRE (Continued)

15.	Do you have a lung disorder; such as, asthma or COPD?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16.	Are you being treated by a psychiatrist or psychologist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17.	Do you have diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18.	High blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19.	Do you have kidney disease or are you on dialysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20.	Do you have cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
21.	Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
22.	Are you living with HIV or AIDS?	<input type="checkbox"/> Yes <input type="checkbox"/> No
23.	Do you have a blood disease, such as sickle cell anemia or Hepatitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
24.	Do you have tuberculosis (TB)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
25.	Is there a child in the house in <ul style="list-style-type: none"> ▪ Part C services, care coordination for children ▪ Any health department program, or does any child receive Case Manager or Care Coordinator services? 	<input type="checkbox"/> Yes <input type="checkbox"/> No List program and/or care coordinator:
26.	Can you think of any other special medical or mental health needs that the MCO might want to know about?	<input type="checkbox"/> Yes <input type="checkbox"/> No List:
27.	Have you been in the hospital in the last 12 months? [If yes] Why were you admitted?	<input type="checkbox"/> Yes <input type="checkbox"/> No Reason:
28.	What is your height?	feet_____ inches_____
29.	What is your weight?	Pounds

Thank you for taking the time to answer these questions. I'll give this information to your new MCO, and they will be in touch with you soon.

If you have any questions or need assistance, please call the Managed Care Help Line at 1-800-MGD-CARE or 1-800-643-2273

6. Medallion II Open Enrollment Effective Dates

NOTE: THESE OPEN ENROLLMENT PERIODS DO NOT APPLY TO FAMIS

CENTRAL VIRGINIA REGION					
LETTERS MAIL LATE JANUARY. MEMBERS CALL FEBRUARY AND MARCH. CHANGES EFFECTIVE APRIL 1.					
001	ACCOMACK	081	GREENSVILLE	133	NORTHUMBERLAND
007	AMELIA	085	HANOVER	135	NOTTOWAY
025	BRUNSWICK	087	HENRICO	730	PETERSBURG
033	CAROLINE	670	HOPEWELL	145	POWHATAN
036	CHARLES CITY	097	KING AND QUEEN	147	PRINCE EDWARD
041	CHESTERFIELD	099	KING GEORGE	149	PRINCE GEORGE
570	COLONIAL HEIGHTS	101	KING WILLIAM	760	RICHMOND CITY
049	CUMBERLAND	103	LANCASTER	159	RICHMOND CO.
053	DINWIDDIE	111	LUNENBURG	175	SOUTHAMPTON
595	EMPORIA	115	MATHEWS	177	SPOTSYLVANIA
057	ESSEX	117	MECKLENBURG	179	STAFFORD
620	FRANKLIN CITY	119	MIDDLESEX	181	SURRY
630	FREDERICKSBURG	127	NEW KENT	183	SUSSEX
075	GOOCHLAND	131	NORTHAMPTON	193	WESTMORELAND
TIDEWATER REGION					
LETTERS MAIL LATE APRIL. MEMBERS CALL MAY AND JUNE. CHANGES EFFECTIVE JULY 1.					
550	CHESAPEAKE	700	NEWPORT NEWS	800	SUFFOLK
073	GLOUCESTER	710	NORFOLK	810	VIRGINIA BEACH
650	HAMPTON	735	POQUOSON	830	WILLIAMSBURG
093	ISLE OF WIGHT	740	PORTSMOUTH	199	YORK
095	JAMES CITY CO.				
NORTHERN AND WINCHESTER REGION					
LETTERS MAIL LATE JUNE. RECIPIENTS CALL JULY AND AUGUST. CHANGES EFFECTIVE SEPTEMBER 1.					
510	ALEXANDRIA	059	FAIRFAX CO.	683	MANASSAS CITY
013	ARLINGTON	610	FALLS CHURCH	685	MANASSAS PARK
043	CLARKE	061	FAUQUIER	153	PRINCE WILLIAM
600	FAIRFAX CITY	107	LOUDOUN	139	PAGE
157	RAPPAHANNOCK	069	FREDERICK	840	WINCHESTER
171	SHENANDOAH	187	WARREN	047	CULPEPER
WESTERN REGION					
LETTERS MAIL LATE AUGUST. MEMBERS CALL SEPTEMBER AND OCTOBER. CHANGES EFFECTIVE NOVEMBER 1.					
003	ALBEMARLE	590	DANVILLE	125	NELSON
009	AMHERST	065	FLUVANNA	137	ORANGE
011	APPOMATTOX	079	GREENE	143	PITTSYLVANIA
015	AUGUSTA	083	HALIFAX	165	ROCKINGHAM
029	BUCKINGHAM	660	HARRISONBURG	790	STAUNTON
031	CAMPBELL	109	LOUISA	820	WAYNESBORO
037	CHARLOTTE	680	LYNCHBURG		
540	CHARLOTTESVILLE	113	MADISON		

Medallion II Open Enrollment Effective Dates (continued)

ROANOKE/ALLEGHANY REGION					
LETTERS MAIL LATE NOVEMBER. MEMBERS CALL DECEMBER AND JANUARY. CHANGES EFFECTIVE FEBRUARY 1.					
005	ALLEGHANY	063	FLOYD	141	PATRICK
017	BATH	067	FRANKLIN CO.	155	PULASKI
515	BEDFORD CITY	071	GILES	750	RADFORD
019	BEDFORD CO.	089	HENRY	770	ROANOKE CITY
023	BOTETOURT	091	HIGHLAND	161	ROANOKE CO.
530	BUENA VISTA	678	LEXINGTON	163	ROCKBRIDGE
580	COVINGTON	690	MARTINSVILLE	775	SALEM
045	CRAIG	121	MONTGOMERY	197	WYTHE
FAR SOUTHWEST REGION					
LETTERS MAIL LATE APRIL. RECIPIENTS CALL MAY AND JUNE. CHANGES EFFECTIVE JULY 1.					
021	BLAND	105	LEE	191	WASHINGTON
027	BUCHANAN	167	RUSSELL	195	WISE
035	CARROLL	169	SCOTT	520	BRISTOL
051	DICKENSON	173	SMYTH	640	GALAX
077	GRAYSON	185	TAZEWELL	720	NORTON

Updated September 1, 2012

7. Medallion II/FAMIS MCO Participation by Locality

Effective July 1, 2012

COUNTIES	FIPS	Amerigroup Community Care	Anthem HealthKeepers Plus	Southern Health CareNet	MajestaCare	Optima Family Care	Virginia Premier Health Plan
ACCOMACK	001		X			X	X
ALBEMARLE	003		X			X	X
ALLEGHANY	005	X	X	X	X	X	X
AMELIA	007		X	X		X	X
AMHERST	009			X		X	X
APPOMATTOX	011			X		X	X
ARLINGTON	013	X	X				
AUGUSTA	015					X	X
BATH	017	X	X	X	X	X	X
BEDFORD COUNTY	019	X	X	X	X	X	X
BLAND	021	X	X	X	X	X	X
BOTETOURT	023	X	X	X	X	X	X
BRUNSWICK	025		X			X	X
BUCHANAN	027	X	X	X	X	X	X
BUCKINGHAM	029		X			X	X
CAMPBELL	031			X		X	X
CAROLINE	033		X	X		X	
CARROLL	035	X	X	X	X	X	X
CHARLES CITY	036		X	X		X	X
CHARLOTTE	037					X	X
CHESTERFIELD	041		X	X		X	X
CLARKE	043	X	X				X
CRAIG	045	X	X	X	X	X	X
CULPEPER	047	X					
CUMBERLAND	049		X	X		X	X
DICKENSON	051	X	X	X	X	X	X
DINWIDDIE	053		X	X		X	X
ESSEX	057		X	X		X	
FAIRFAX COUNTY	059	X	X				
FAUQUIER	061	X	X				
FLOYD	063	X	X	X	X	X	X
FLUVANNA	065		X			X	X
FRANKLIN COUNTY	067	X	X	X	X	X	X
FREDERICK	069	X	X				X
GILES	071	X	X	X	X	X	X
GLOUCESTER	073		X			X	
GOOCHLAND	075		X	X		X	X
GRAYSON	077	X	X	X	X	X	X
GREENE	079		X			X	X
GREENSVILLE	081		X			X	X
HALIFAX	083		X			X	X
HANOVER	085		X	X		X	X
HENRICO	087		X	X		X	X
HENRY	089	X	X	X	X	X	X
HIGHLAND	091	X	X	X	X	X	X
ISLE OF WIGHT	093		X			X	X
JAMES CITY COUNTY	095		X			X	
KING & QUEEN	097		X	X		X	
KING GEORGE	099		X				X
KING WILLIAM	101		X	X		X	X

Medallion II/FAMIS MCO Participation by Locality

Effective July1, 2012

COUNTIES	FIPS	Amerigroup Community Care	Anthem HealthKeepers Plus	Southern Health CareNet	MajestaCare	Optima Family Care	Virginia Premier Health Plan
LANCASTER	103		X	X		X	
LEE	105	X	X	X	X	X	X
MIDDLESEX	119		X	X		X	
MONTGOMERY	121	X	X	X	X	X	X
LOUDOUN	107	X	X				
LOUISA	109		X			X	X
LUNENBURG	111		X	X		X	X
MADISON	113	X	X			X	
MATHEWS	115		X	X		X	
MECKLENBURG	117		X	X		X	X
NELSON	125		X			X	X
NEW KENT	127		X	X		X	X
NORTHAMPTON	131		X			X	X
NORTHUMBERLAND	133		X	X		X	
NOTTOWAY	135		X	X		X	X
ORANGE	137	X	X			X	
PAGE	139	X	X			X	X
PATRICK	141	X	X	X	X	X	X
PITTSYLVANIA	143					X	X
POWHATAN	145		X	X		X	X
PRINCE EDWARD	147		X			X	X
PRINCE GEORGE	149		X	X		X	X
PRINCE WILLIAM	153	X	X				
PULASKI	155	X	X	X	X	X	X
RAPPAHANNOCK	157	X	X				
RICHMOND COUNTY	159		X	X		X	
ROANOKE COUNTY	161	X	X	X	X	X	X
ROCKBRIDGE	163	X	X	X	X	X	X
ROCKINGHAM	165					X	X
RUSSELL	167	X	X	X	X	X	X
SCOTT	169	X	X	X	X	X	X
SHENANDOAH	171	X	X				X
SMYTH	173	X	X	X	X	X	X
SOUTHAMPTON	175		X			X	X
SPOTSYLVANIA	177		X				X
STAFFORD	179		X				X
SURRY	181		X	X		X	X
SUSSEX	183		X	X		X	X
TAZEWELL	185	X	X	X	X	X	X
WARREN	187	X	X				
WASHINGTON	191	X	X	X	X	X	X
WESTMORELAND	193		X	X		X	X
WISE	195	X	X	X	X	X	X
WYTHE	197	X	X	X	X	X	X
YORK	199		X			X	

Cities are listed on the next page

Medallion II/FAMIS MCO Participation by Locality

Effective July 1, 2012

Cities	FIPS	Amerigroup Community Care	Anthem HealthKeepers Plus	Southern Health CareNet	MajestaCare	Optima Family Care	Virginia Premier Health Plan
ALEXANDRIA	510	X	X				
BEDFORD CITY	515	X	X	X	X	X	X
BRISTOL	520	X	X	X	X	X	X
BUENA VISTA	530	X	X	X	X	X	X
CHARLOTTESVILLE	540		X			X	X
CHESAPEAKE	550		X			X	X
COLONIAL HEIGHTS	570		X	X		X	X
COVINGTON	580	X	X	X	X	X	X
DANVILLE	590					X	X
EMPORIA	595		X			X	X
FAIRFAX CITY	600	X	X				
FALLS CHURCH	610	X	X				
FRANKLIN CITY	620		X			X	X
FREDERICKSBURG	630		X				X
GALAX	640	X	X	X	X	X	X
HAMPTON	650		X			X	X
HARRISONBURG	660					X	X
HOPEWELL	670		X	X		X	X
LEXINGTON	678	X	X	X	X	X	X
LYNCHBURG	680			X		X	X
MANASSAS CITY	683	X	X				
MANASSAS PARK	685	X	X				
MARTINSVILLE	690	X	X	X	X	X	X
NEWPORT NEWS	700		X			X	X
NORFOLK	710		X			X	X
NORTON	720	X	X	X	X	X	X
PETERSBURG	730		X	X		X	X
POQUOSON	735		X			X	
PORTSMOUTH	740		X			X	X
RADFORD	750	X	X	X	X	X	X
RICHMOND CITY	760		X	X		X	X
ROANOKE CITY	770	X	X	X	X	X	X
SALEM	775	X	X	X	X	X	X
STAUNTON	790					X	X
SUFFOLK	800		X			X	X
VIRGINIA BEACH	810		X			X	X
WAYNESBORO	820					X	X
WILLIAMSBURG	830		X			X	
WINCHESTER	840	X	X				X

8. Hospitalized at Time of MCO Enrollment

MEDICAID

Medicaid recipients who are hospitalized under fee-for-service at the time of initial enrollment in the Medallion II (Medicaid MCO) program are disenrolled from the MCO upon notification to DMAS by the admitting hospital or the MCO. These individuals are covered by DMAS fee-for-service until they are discharged from the hospital; providers are required to follow DMAS coverage criteria and reimbursement guidelines. Generally, these individuals will be enrolled in the MCO on the first day of the next month after discharge. In order for DMAS to handle MCO disenrollment's timely, **hospitals must notify the DMAS Managed Care Unit monthly of any Medicaid individuals who are hospitalized overnight on the last day of each month by sending the "Report of Overnight Medicaid or MCO/Medicaid Patients on Last Day of the Month" form by fax to 804-786-5799.** Questions can be sent to managedcarehelp@dmass.virginia.gov. Please do not send protected health information via unencrypted email.

For Medicaid recipients who are enrolled with a DMAS contracted MCO at the time of admission, where the MCO contracts with the hospital on a DRG basis, the MCO is responsible for the full DRG (admission to discharge) – in accordance with the MCO coverage criteria and reimbursement guidelines. Where the MCO and hospital have a per-diem based reimbursement contract, the MCO covers the hospitalization for the dates in which the individual is enrolled with the MCO.

FAMIS

FAMIS recipients who are hospitalized under FAMIS fee-for-service at the time of initial enrollment into a FAMIS MCO are **NOT** disenrolled from the MCO. For acute care hospital admissions (medical/surgical services), for FAMIS fee-for-service members, DMAS will cover the full DRG from admission to discharge. For inpatient rehabilitation and inpatient psychiatric admissions for individuals who are in FAMIS fee-for-service at the time of admission, DMAS covers the hospitalization from the date of admission until the effective date in the MCO. Where the MCO and hospital have a per-diem based reimbursement contract, the MCO covers the hospitalization for the dates in which the individual is enrolled with the MCO. For fee-for-service coverage, providers are required to follow DMAS coverage criteria and reimbursement guidelines. Similarly, coverage through the MCO follows MCO established criteria/guidelines. Questions can be sent to managedcarehelp@dmass.virginia.gov. Please do not send protected health information via unencrypted email.

For FAMIS recipients who are enrolled with a DMAS contracted MCO at the time of admission, where the MCO contracts with the hospital on a DRG basis, the MCO is responsible for the full DRG (admission to discharge) – in accordance with the MCO coverage criteria and reimbursement guidelines. Where the MCO and hospital have a per-diem based reimbursement contract, the MCO covers the hospitalization for the dates in which the individual is enrolled with the MCO.

REPORT OF OVERNIGHT MEDICAID OR MCO/MEDICAID PATIENTS ON LAST DAY OF THE MONTH

[illegible]

Revised April 19, 2012

CARE FOR KIDS

9. Early and Periodic Screening, Diagnosis, and Treatment Services

What is EPSDT?

Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) is a comprehensive and preventive child health program for members under the age of 21 that is required by the federal government to be a part of every state's Medicaid package.

Under the Social Security Act Section 1905(r)(5), states are required to provide any medically necessary health care services listed at Section 1905 (a) of the Social Security Act to correct and/or ameliorate physical and mental conditions discovered during screening services even if the service is not included under the state's Medicaid plan. This includes periodic screening, vision, dental and hearing services.

Virginia's EPSDT program goals are to keep children as healthy as possible by:

- Assuring that health concerns are diagnosed as early as possible,
- Assuring that treatment is provided before problems become complex, and
- Assuring that medically justified services are provided to treat or correct identified problems

Who is eligible for EPSDT Services?

- Children under the age of 21 who receive Medicaid through Medicaid/FAMIS Plus fee-for-service or a MCO.
- FAMIS children who are enrolled in fee-for-service. MCO enrolled FAMIS children are not eligible for the full scope of EPSDT services.

EPSDT screenings are conducted by physicians, physician assistants or certified nurse practitioners and can occur during the following:

- Initial Screening – This is a checkup provided when the child enters Medicaid.
- Periodic Screening – Check up that should occur at regular intervals. Virginia uses the American Academy of Pediatrics and Bright Futures guidelines to develop the Virginia EPSDT periodicity schedule.
- Inter-periodic Screening – unscheduled check-up or problem focused assessment that can happen at any time because of illness or a change in condition. Any caregiver or professional who interacts with the member may request the screening.

What are the required components in EPSDT screenings?

- Comprehensive unclothed physical exam
 - Patient and family medical history including identifying risk factors for health and mental health status
 - Developmental, Vision and Hearing Screening
 - Preventive laboratory services including
 - *Mandatory Lead testing at 12 months and 24 months*
 - Age appropriate Immunizations
 - Referral to a dentist at age 1
 - Age appropriate anticipatory guidance/health counseling
 - Referrals for medically necessary health and mental health treatment
-

All requests for EPSDT treatment services must:

- Be deemed medically necessary to correct or ameliorate a health or mental health condition; and,
- Have the need for specialist referral or treatment documented during an EPSDT screening.

Services that are considered experimental or investigational are not covered.

EPSDT Specialized Services are medically necessary treatment services that are not a routinely covered service through Virginia Medicaid. All EPSDT “specialized services” must be a service that is allowed by the Centers for Medicare and Medicaid Services (CMS). The allowable treatment services are defined in the United States Code in 42 U.S.C. sec 1396d (r) (5).

The most frequently provided EPSDT specialized services are:

- Hearing Aids
- Assistive Technology
- Personal Care
- Private Duty Nursing
- Behavioral Therapy
- Medical Formula and Medical Nutritional Supplements
- Specialized Residential Behavioral Therapy and Residential Treatment
- Substance Abuse Residential Treatment Services

DMAS Contact: EPSDT@dmass.virginia.gov or 804-786-6134

EPSDT Screening Procedure Codes

DESCRIPTION	Age	CPT Code
INITIAL SCREENINGS		
Newborn Care (outpatient)	Normal newborn care	99432
New Member	less than 1 year of age	99381*
New Member	1-4 years of age	99382*++
New Member	5-11 years of age	99383*
New Member	12-17 years of age	99384*
New Member	18-20 years of age	99385*
PERIODIC SCREENINGS		
Established Member	less than 1 year of age	99391*
Established Member	1-4 years of age	99392*++
Established Member	5-11 years of age	99393*
Established Member	12-17 years of age	99394*
Established Member	18-20 years of age	99395*
DEVELOPMENTAL TESTING (Instrument, Interpretation/Report)		
Screening	0-20 years of age	96110
Extended	0-20 years of age	96111
LEAD TESTING (Mandatory at 12 mos. and 24 mos. of age)		
Testing (by Lab)	0-20 years of age	83655
Venous Sample	0-20 years of age	36415
Capillary Sample	0-20 years of age	36416
Specimen Handling	0-20 years of age	99000
VISION SCREENING		
Vision	3-20 years of age	99173
HEARING SCREENING		
Hearing	0-20 years of age	92551

**Use appropriate Immunization Codes for scheduled immunizations*

++ Lead Testing required at 12 and 24 months

10. Virginia Vaccines For Children (VVFC) Program

Virginia Vaccines For Children provides federally purchased vaccine, at no cost to health care providers, for administration to eligible children. Some Medallion II PCPs participate in Virginia Vaccines For Children.

Medicaid, FAMIS Plus (Children's Medicaid):

Age 0-18----eligible for VVFC

- DMAS will not reimburse the acquisition cost for vaccines covered under VVFC.
- DMAS will reimburse an appropriate office visit or preventive medicine fee.
- DMAS will reimburse the provider an administration fee (\$11.00) for each vaccine.

Age 19-20---not eligible for VVFC

- DMAS will reimburse the provider the acquisition cost.
- DMAS will reimburse an appropriate office visit or preventive medicine fee.
- DMAS will **not** reimburse an administration fee.

FAMIS:

Age 0-18---not eligible for VVFC

Children enrolled in FAMIS are not eligible for VFC. They are not Medicaid.

- DMAS will reimburse the provider the acquisition cost.
- DMAS will reimburse an appropriate office visit fee.
- DMAS will reimburse an administration fee (\$11.00).

To ensure proper reimbursement by DMAS:

- Use the Evaluation and Management CPT code for the appropriate office visit or Preventive Medicine Service (EPSDT Screening Procedure Code).
- Always bill your usual and customary fee.
- Use the CPT code for the immunization. Bill the usual and customary cost plus \$11.00.
- Complete 11d appropriately.
- The DMAS claims system will read the member/FAMIS enrollee file and pay accordingly.

Medallion II:

Medicaid and FAMIS members enrolled in a Virginia Medicaid contracted MCO:

Member eligibility for Virginia Vaccines For Children is the same as above.

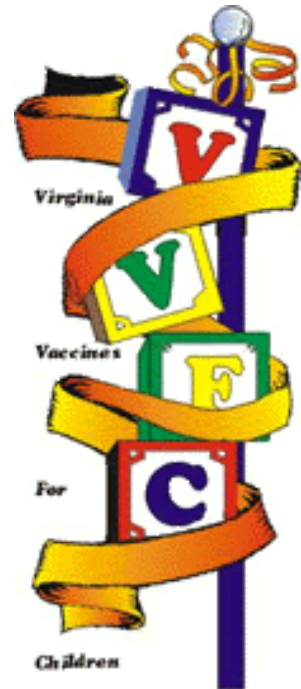
Providers participating in Medallion II should contact their MCO for billing instructions.

Virginia Vaccines For Children:

VVFC covers children who are less than 19 years of age and meet one of the following criteria:

- Medicaid enrolled
- Uninsured (no health insurance)
- American Indian or Alaskan Native
- Under insured (commercial insurance coverage does not include vaccines). *These children must go to a Federally Qualified Health Center, Rural Health Center or local Health Department.*

For more information on VVFC call 800-568-1929 or 804-864-8055



11. MCO Reimbursement for “BabyCare” Services

	DMAS BabyCare	Amerigroup Taking Care of Baby and Me	Anthem Future Moms	CareNet Baby Matters	MajestaCare	Optima Partners in Pregnancy	Virginia Premier Healthy Heartbeats
Contact Information	<p>Ashley Harrell Tabitha Taylor</p> <p>DMAS Maternal and Child Health Division 600 East Broad Street Suite 1300 Richmond, VA 23219</p> <p>804-786-6134 Fax: 804-612-0043</p> <p>BabyCare@dmass.virginia.gov</p>	<p>Sandra Stewart, RN OB Case Manager 925-462-7367 Sstewa2@amerigroupcorp.com</p> <p>Jane Fletcher, RN OB Case Manager 925-286-3984 jfletch@amerigroupcorp.com</p> <p>Wendl Barton, RN NICU Case Manager 925-462-7369 Wbarton@amerigroupcorp.com</p> <p>Katina Waller Newborn Coordinator 703-286-3987 Fax: 1-888-393-8978 kwaller@amerigroupcorp.com Amerigroup Corporation 2600 Park Tower Drive, Suite #600, Vienna, VA 22180</p>	<p>Elaine Moberley, Nurse Case Manager, 1-800-518-8584 opt#1 ext 5336</p> <p>Future Moms Program 1-800-828-5891</p> <p>Authorization of Anthem Benefits & Services 1-800-533-1120</p> <p>Anthem Member/ Provider Services 1-800-901-0200</p>	<p>Sue Molnar 9881 Mayland Drive Richmond, VA 23233 smolnar@cvtv.com 804-747-3700, ext. 1259 Fax: 804-527-7059</p>	<p>Rosemary Winslow or Carol Furry</p> <p>MajestaCare 213 S. Jefferson Street Ste 101 Roanoke, VA 24011</p> <p>866-996-9140 Fax: 855-388-0430</p>	<p>1-866-239-0618</p>	<p>Tidewater: Shelia Barnes - sbarnes@vapremier.com 757-461-0064, ext. 5571</p> <p>Central Va.: Regina Collier – rcollier@vapremier.com 804-819-5151, ext. 5353</p> <p>Roanoke: Martha Meadows - mmeadows2@vapremier.com 504-344-8838, ext. 5832</p>
Reimburse for case management services (G9002)?	Yes	No	Refer to FFS provider case by case basis only	Yes	Yes	Refer to FFS provider case by case basis only	Yes
Require prior authorization (PA)?	Yes	N/A	Yes	No	No	Yes	Yes
Reimburse for patient education classes (S9442 and S9446)?	Yes	Yes	No	Yes	Yes	Use S9446	Yes
Require PA?	No	Yes, for non-par provider only	n/a	No	No for S9442 Yes for S9446	No	Yes

MCO Reimbursement for “BabyCare” Services (continued)

	DMAS BabyCare	Amerigroup Taking Care of Baby and Me	Anthem Future Moms	CareNet Baby Matters	MajestaCare	Optima Partners in Pregnancy	Virginia Premier Healthy Heartbeats
Reimburse for Behavioral Health Risk Screen (99420)?	Yes	Yes	No	Yes	Yes	Yes	Yes
Accept DMAS-16 (P)rovider and (S)elf- questionnaire?	Yes	Yes	N/A	Yes	Yes	Yes	Yes
Require PA?	No	Yes, for non-par provider only	N/A	No	No	No	No
Reimburse for case management assessment (G9001)?	Yes	Yes	No	Yes	Yes	Yes	Yes
Accept DMAS-50 (M)aternal and (I)nfant?	Yes	Yes	n/a	Yes	Yes	Yes	Yes
Require PA?	No	Yes, for non-par provider only	No	No	No	No	Yes
Reimburse for nutritional assessment (97802)?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Require PA?	No	Yes, for non-par provider only	No (if in office setting)	No	No	Yes	Yes
Reimburse for nutritional counseling and follow up visit (97803)?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Require PA?	No	Yes, for non-par provider only	No (if in office setting)	No	No	Yes	Yes